Washington State Department of Health

Send completed forms to DOH Communicable Disease Epidemiology **Fax: 206-361-2930**

Hepatitis C, acute

County

LHJ Use **ID** _____
☐ **Reported to DOH** **Date** ___/___/___
LHJ Classification ☐ **Confirmed** ☐ **Probable**
By: ☐ **Lab** ☐ **Clinical** ☐ **Other:** _____
Outbreak # (LHJ) _____ **(DOH)** _____

DOH Use ***ID*** _____
Date Received ___/___/___
DOH Classification
☐ ***Confirmed***
☐ ***Probable***
☐ ***No count; reason:***

REPORT SOURCE

Initial report date ___/___/___
Reporter (check all that apply)
☐ Lab ☐ Hospital ☐ HCP
☐ Public health agency ☐ Other
OK to talk to case? ☐ Yes ☐ No ☐ Don't know

Reporter name _____
Reporter phone _____
Primary HCP name _____
Primary HCP phone _____

PATIENT INFORMATION

Name (last, first) _____
Address _____ ☐ Homeless
City/State/Zip _____
Phone(s)/Email _____
Alt. contact ☐ Parent/guardian ☐ Spouse ☐ Other Phone: _____
Occupation/grade _____
Employer/worksite _____ School/child care name _____

Birth date ___/___/___ Age _____
Gender ☐ F ☐ M ☐ Other ☐ Unk
Ethnicity ☐ Hispanic or Latino
☐ Not Hispanic or Latino
Race (check all that apply)
☐ Amer Ind/AK Native ☐ Asian
☐ Native HI/other PI ☐ Black/Afr Amer
☐ White ☐ Other

CLINICAL INFORMATION

Onset date: ___/___/___ ☐ Derived Diagnosis date: ___/___/___ Illness duration: _____ days

Signs and Symptoms

Y	N	DK	NA	
☐	☐	☐	☐	**Discrete onset of symptoms**
☐	☐	☐	☐	Diarrhea Maximum # of stools in 24 hours: ____
☐	☐	☐	☐	**Pale stool, dark urine (jaundice)** Onset date ___/___/___
☐	☐	☐	☐	**Abdominal cramps or pain**
☐	☐	☐	☐	**Nausea**
☐	☐	☐	☐	**Vomiting**
☐	☐	☐	☐	**Loss of appetite (anorexia)**
☐	☐	☐	☐	**Fatigue**

Predisposing Conditions

Y	N	DK	NA	
☐	☐	☐	☐	Pregnant Estimated delivery date ___/___/___ OB name, address, phone: _____ _____

Clinical Findings

Y	N	DK	NA	
☐	☐	☐	☐	Complications, specify: _____

Hospitalization

Y	N	DK	NA	
☐	☐	☐	☐	Hospitalized for this illness

Hospital name _____
Admit date ___/___/___ Discharge date ___/___/___

Y	N	DK	NA	
☐	☐	☐	☐	Died from illness Death date ___/___/___
☐	☐	☐	☐	Autopsy

Vaccinations

Y	N	DK	NA	
☐	☐	☐	☐	Received any doses of hepatitis A vaccine Year of last HAV vaccine dose: _____ Number of doses of HAV vaccine in past: _____
☐	☐	☐	☐	Received any doses of hepatitis B vaccine Year of last HBV vaccine dose: _____ Number of doses of HBV vaccine in past: _____ If 3 hepatitis B vaccine doses, titer of HBV antibody test 1-6 mo's from third HBV dose: _____

Laboratory

Collection date ___/___/___

Y	N	DK	NA	
☐	☐	☐	☐	**IgM antibody to hepatitis A virus (anti-HAV) positive**
☐	☐	☐	☐	**IgM antibody to hepatitis core antigen (anti-HBc) positive**
☐	☐	☐	☐	**HBsAg positive**
☐	☐	☐	☐	**HCV RNA detected by nucleic acid amplification test [NAAT]**
☐	☐	☐	☐	**HCV RIBA positive**
☐	☐	☐	☐	**Repeatedly reactive anti-HCV EIA with signal to cut-off ratio >= 3.8**
☐	☐	☐	☐	**Serum aminotransferase (SGOT (AST), SGPT (ALT)) elevated above normal**
☐	☐	☐	☐	**Serum aminotransferase (SGOT [AST] or SGPT [ALT]) levels >7 times the upper limit of normal**

Case defining variables are in **bold.** Answers are: Yes, No, Unknown to case, Not asked /Not answered

INFECTION TIMELINE

Enter jaundice onset date in heavy box. Count forward and backward to figure probable exposure and contagious periods

	Exposure period		***Contagious period****
Days from onset:	-180	-15	1+ weeks prior onset to indefinite period after onset
Calendar dates:			

** Lifelong if chronic infection*

EXPOSURE (Refer to dates above)

Y N DK NA

- ☐ ☐ ☐ ☐ Travel out of the state, out of the country, or outside of usual routine
  Out of: ☐ County ☐ State ☐ Country
  Dates/Locations: _____
- ☐ ☐ ☐ ☐ Case knows anyone with similar symptoms
- ☐ ☐ ☐ ☐ Contact with confirmed or suspect hepatitis C case
  ☐ Household ☐ Sexual
  ☐ Needle use ☐ Other: _____
- ☐ ☐ ☐ ☐ Birth mother has history of hepatitis C infection
- ☐ ☐ ☐ ☐ Birth mother - HBsAg positive
- ☐ ☐ ☐ ☐ Congregate living Type:
  ☐ Barracks ☐ Corrections ☐ Long term care
  ☐ Dormitory ☐ Boarding school ☐ Camp
  ☐ Shelter ☐ Other: _____
- ☐ ☐ ☐ ☐ Hospitalized during exposure period
- ☐ ☐ ☐ ☐ Any medical or dental procedure:
- ☐ ☐ ☐ ☐ Hemodialysis
- ☐ ☐ ☐ ☐ IV or injection as outpatient
- ☐ ☐ ☐ ☐ Blood transfusion or blood products (e.g. IG, factor concentrates) Date of receipt: __/__/__
- ☐ ☐ ☐ ☐ Organ or tissue transplant recipient, date:__/__/__
- ☐ ☐ ☐ ☐ Dental work or oral surgery
- ☐ ☐ ☐ ☐ Non-oral surgery type: _____
- ☐ ☐ ☐ ☐ Acupuncture
- ☐ ☐ ☐ ☐ Employed in job with potential for exposure to human blood or body fluids Job type:
  ☐ Public Safety ☐ Health care (e.g. medical, dental, laundry) ☐ Tattoo or piercing ☐ Other
  Frequency of direct blood or body fluid exposure
  ☐ Frequent (several times weekly)
  ☐ Infrequent ☐ Unknown

Y N DK NA

- ☐ ☐ ☐ ☐ Employed in dialysis or kidney transplant unit
- ☐ ☐ ☐ ☐ Accidental parenteral exposure to blood
- ☐ ☐ ☐ ☐ Accidental non-intact skin or mucous membrane exposure to blood
- ☐ ☐ ☐ ☐ Body piercing
  ☐ Home ☐ Commercial ☐ Prison ☐ Unk
- ☐ ☐ ☐ ☐ Tattooing
  ☐ Home ☐ Commercial ☐ Prison ☐ Unk
- ☐ ☐ ☐ ☐ Other body modification (e.g. scarification)
- ☐ ☐ ☐ ☐ Shared razor, toothbrushes or nail care items
- ☐ ☐ ☐ ☐ Non-injection street drug use
  Shared equipment non-IDU ☐**Y** ☐**N** ☐**DK** ☐**NA**
- ☐ ☐ ☐ ☐ Injection street drug use, type: _____
  Shared injection equipment ☐**Y** ☐**N** ☐**DK** ☐**NA**
- ☐ ☐ ☐ ☐ Born outside US
- ☐ ☐ ☐ ☐ Household or sexual contact from endemic country, specify country: _____
- ☐ ☐ ☐ ☐ Any type of sexual contact with others
  # lifetime total sexual partners: _____
  # female sexual partners: _____
  # male sexual partners: _____
- ☐ ☐ ☐ ☐ Physical assault on exposed person involving blood or semen
- ☐ ☐ ☐ ☐ Ever diagnosed with an STD
  Treated for STD ☐**Y** ☐**N** ☐**DK** ☐**NA**
  Year of most recent treatment: _____
- ☐ ☐ ☐ ☐ Other blood or body fluid exposure
  Other exposure source: _____

☐ **Patient could not be interviewed**
☐ **No risk factors or exposures could be identified**

Most likely exposure/site: _____ **Site name/address:** _____

Where did exposure probably occur? ☐ In WA (County: _____) ☐ US but not WA ☐ Not in US ☐ Unk

PUBLIC HEALTH ISSUES

Y N DK NA

- ☐ ☐ ☐ ☐ Employed as health care worker, if yes: Employed in a job with human blood exposure: ☐ Several times a week ☐ Infrequently ☐ No ☐ Unknown
- ☐ ☐ ☐ ☐ Patient in a dialysis or kidney transplant unit
- ☐ ☐ ☐ ☐ Did case donate blood products, organs or tissue (including ova or semen) in the 30 days before symptom onset Date: ___/___/___
  Agency and location: _____
  Specify type of donation: _____
- ☐ ☐ ☐ ☐ Outbreak related

PUBLIC HEALTH ACTIONS

- ☐ Notify blood or tissue bank
- ☐ Health care worker performing invasive procedures
- ☐ Other, specify: _____

Investigator _____ **Phone/email:** _____ **Investigation complete date** ___/___/___

Local health jurisdiction _____

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